**INDIANA STATE DEPARTMENT OF HEALTH**
**LONG TERM CARE**
**Test Application for Qualified Medication Aide**
**State Form 17213 (R 3/10-01)**
Form approved by State Board of Accounts - 2001

Submit application, fee and documentation to:
Professional Resources, PO Box 1552,
Valparaiso, IN 46384

**OFFICE USE ONLY – DO NOT WRITE IN THIS AREA**

| CANDIDATE NO.: | TEST NO.: | SCORE: | TEST DATE: | TEST FEE ENCLOSED: | STUDENT STATUS: |
|---|---|---|---|---|---|
| | | | | _____ Y _____ N<br>Check or money order #:<br>_____ | ❑ completed ISDH approved course<br>❑ out of state QMA<br>❑ currently enrolled nursing student |

## SECTION 1. APPLICANT INFORMATION – typed or printed legibly

Applicant's LEGAL Name:_____ Sex:_____F _____M
Last First M.I.

Address:_____ Phone #:_(_____)_____

City, State, Zip:_____ County:_____

Birth Date:_____ C.N.A. Registry #:_____ SS#:_____

**PRIVACY NOTICE TO APPLICANT: This state agency is requesting disclosure of your Social Security number to accomplish its purpose under IC 4-18. Disclosure is voluntary and you will not be penalized for refusal.**

## SECTION 2. REQUIRED DOCUMENTATION

The following **required** documents are attached to this application:

❑ copy of high school diploma and/or transcript or GED certificate
❑ **ORIGINAL** QMA practicum worksheet
❑ copy of Indiana Nurse Aide Registry certification letter
❑ $20.00 test fee (check or money order) **payable to the INDIANA STATE DEPARTMENT OF HEALTH** (fee subject to change without notice)
❑ out-of-state documentation, if applicable
❑ nursing school transcript, if applicable

## SECTION 3. ISDH APPROVED MEDICATION COURSE INFORMATION

***CLASSROOM:***

FACILITY/SCHOOL NAME:_____ PHONE:_____

Address:_____ QMA training site number:_____

City, State, Zip:_____ County:_____

Date 40 hours of classroom completed:_____ RN instructor:_____

I verify this applicant has successfully completed at least 40 hours of classroom instruction using the ISDH approved *Medication Administration for Unlicensed Nursing Personnel* course, and all master tests were completed and available in this applicant's training file.

RN instructor's signature (in red ink):_____ RN license #:_____ Date:_____

***PRACTICUM:***

Name of facility:_____ Facility number:_____

RN practicum Supervisor:_____

Date practicum completed:_____ Number of hours completed:_____

I verify this applicant has successfully completed at least 20 hours of practical experience administering medications under my supervision using the ISDH approved *Medication Administration for Unlicensed Nursing Personnel* course check lists.

RN Practicum Supervisor's signature (in red ink):_____ RN License #:_____ Date:_____

## SECTION 4. APPLICANT VERIFICATION

I verify all of the above information is correct. I understand falsification of this document may result in denial or revocation of my qualifications.

Applicant's signature:_____ Date:_____